HB-0627-0403q

State of New Jersey - Department of the Treasury
Division of Pensions and Benefits

STATE HEALTH BENEFITS PROGRAM

Return to: HIPAA Privacy Officer
State Health Benefits Program
PO Box 295
Trenton, NJ 08625-0295

PARTICIPANT AUTHORIZATION FORM

FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Participant's Name: _____
LAST FIRST MI

Address: _____

_____

Daytime Telephone Number: (_____) _____ **E-mail:** _____
AREA CODE

Participant's Social Security Number: _____

By signing this authorization form I, (print name) _____, authorize the State Health Benefits Program (SHBP) to use and/or disclose my health information (information that constitutes protected health information as defined in the Privacy Rule of the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act [HIPAA] of 1996) in the manner described below. The SHBP will not condition treatment, payment, enrollment in a health plan, or eligibility for health care benefits on my decision to sign this authorization.

I have signed this form voluntarily to document my wishes regarding the use and/or disclosure of the health information described below.

1. Description of Health Information I Authorize to be Used or Disclosed. The following is a specific description of the health information I authorize be used and/or disclosed:

_____

_____

_____

2. Description of Each Purpose for the Requested Use and/or Disclosure. I authorize my health information to be used and/or disclosed for the following specific purposes:

_____

_____

_____

3. Persons/Organizations Authorized to Receive and/or Use My Health Information. I authorize the following person(s) and/or organization(s) to receive my health information from the SHBP and to use or disclose such information for the purposes listed above. I understand that the health information disclosed pursuant to this authorization may no longer be protected by the federal privacy standards and may be redisclosed without obtaining my authorization.

_____

_____

_____

Continued on next page

4. Right to Revoke. I understand that I have the right to revoke this authorization at any time and that my revocation of this authorization must be in writing. I understand that any revocation must include my name, address, telephone number, the date of this authorization, and my signature and that I should send it to the State Health Benefits Program — HIPAA Privacy Officer, State of New Jersey, Department of the Treasury, Division of Pensions and Benefits, PO Box 295, Trenton, NJ 08625-0295. I am aware that my revocation will not be effective as to uses and/or disclosures of my health information that have already been made in reliance upon this authorization.

5. Expiration of Authorization. This authorization will expire (check one and complete):

☐ On: _____/_____/_____
MM / DD / YYYY

☐ Upon the occurrence of the following event(s) or until I revoke this authorization:

_____

_____

PARTICIPANT'S SIGNATURE

I have had an opportunity to review and understand the contents of this form. By signing this form, I am confirming that it accurately reflects my wishes.

_____ **Date:** _____/_____/_____
PARTICIPANT'S SIGNATURE MM / DD / YYYY

If signed by a personal representative, complete the following:

Name of Personal Representative: _____

Relationship to Participant or Nature of Authority: _____
(e.g., health care power of attorney, guardian, other statutory authorization — **A copy of documentation must be attached**.):

Address: _____

_____

Daytime Telephone Number: (_____) _____ **E-mail:** _____
AREA CODE

_____ **Date:** _____/_____/_____
SIGNATURE OF PERSONAL REPRESENTATIVE MM / DD / YYYY